| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315314 | A. BUILDING **01**<br>B. WING _____ | **05/21/2021** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **ANCHOR CARE AND REHABILITATION CENTER** | **3325 HIGHWAY 35**<br>**HAZLET, NJ 07730** |

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| E 000 | Initial Comments<br><br>This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities. | E 000 | | |
| K 000 | INITIAL COMMENTS<br><br>A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 05/12/21 was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies.<br><br>Anchor Care & Rehab Center is a three story building that was built in 1950's. It is composed of Type T-11 protected construction. The facility is divided into eight smoke zones. | K 000 | | |
| K 252<br>SS=D | Number of Exits - Corridors<br>CFR(s): NFPA 101<br><br>Number of Exits - Corridors<br>Every corridor shall provide access to not less than two approved exits in accordance with Sections 7.4 and 7.5 without passing through any intervening rooms or spaces other than corridors or lobbies.<br>18.2.5.4, 19.2.5.4<br><br>This REQUIREMENT is not met as evidenced | K 252 | | 7/23/21 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 06/03/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| K 252 | Continued From page 1<br>by:<br>Based on observation from 05/12/21, in the presence of the Maintenance Director and Regional Plant Operations Director, it was determined that the facility failed to ensure that every corridor of the building was provided with two approved exits without passing through any intervening rooms.<br><br>This deficient practice was evidenced by the following:<br><br>The [redacted] floor exit, from the [redacted] floor [redacted] Wing, was located in the [redacted] floor [redacted] Wing dayroom, which would require passing through the dayroom to reach the exit.<br><br>The [redacted] floor exit, from the [redacted] floor [redacted] Wing, was located in the [redacted] floor [redacted] Wing dayroom, which would require passing through the dayroom to reach the exit.<br><br>The Administrator was provided documentation on 05/12/21 at 09:15 AM, indicating: Instructions for past "WAIVERED" citations. A facility is required to have an onsite, physical Fire Safety Evaluation System (FSES) survey conducted (annually).<br><br>NJAC 8:39-31.2(e) | K 252 | Facility has a fire detection system within the facility that is tested semi annually. There is also an approved fire sprinkler/suspension system within the facility which is checked quarterly. Exit signs are clearly marked with lighting which is checked monthly for operation. Fire compartment is made of proper fire rated materials along with proper 90 minute rated fire doors leading to the fire compartment. There are extinguishers located within the unit available to staff for use in case of emergency checked monthly.<br><br>A. The equivalent level of safety is provided by the FSES.<br>B. None of our residents have been affected by this issue.<br>C. These areas are free from clutter and can be accessed easily.<br>D. These areas are monitored regularly by maintenance and nursing to ensure that they are free of clutter so the exit can be easily accessed.<br><br>We have done the FSES survey with an independent consultant, as required by the state and we passed the survey on 7/14/2021. | |
| K 271<br>SS=D | Discharge from Exits<br>CFR(s): NFPA 101<br><br>Discharge from Exits<br>Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the | K 271 | | 6/4/21 |

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| K 271 | Continued From page 2<br>provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview, the facility failed to keep an exit discharge path maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency in accordance with NFPA 101, 2012 LSC Edition, Section 19.2.1, 7.1, 7.1.6, 7.1.6.1, 7.1.6.1.1, 7.1.10, 7.1.10.1, 7.7 and 7.7.1.<br><br>This deficient practice was evidenced by the following:<br><br>The surveyor observed on 05/12/21 at approximately 1:19 PM the resident day- room had 1 of 2 exit discharge paths that were not maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. The exit discharge was blocked by an approximately 12' x 12' white tent. The tent obstructed direct access to the public way.<br><br>The findings were verified by the Maintenance Director and Regional Plant Operations Director at the time of the observation.<br><br>The Administrator was informed of the findings at the Life Safety Code exit conference.<br><br>NJAC 8:39-31.2(e) | K 271 | 1) The white 12x12 visitors tent obstructing the 1st floor day room exit was removed on 05/12/2021 to ensure direct access in case of fire<br>2) The facility maintenance director inspected all other emergency exits and no other obstructions were noted to be impeding any emergency exits.<br>3) Any questionable items regarding emergency exits, maintenance director will reach out to our fire consultant for guidance. Our fire consultant will also round monthly to look for any obstruction blocking fire exits.<br>4) The Maintenance Director or designee will round weekly x 4 weeks and then monthly x 6 thereafter to ensure all exits are free of obstructions. He will report his findings at the quarterly QA committee. | |
| K 341<br>SS=F | Fire Alarm System - Installation<br>CFR(s): NFPA 101 | K 341 | | 6/4/21 |

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| K 341 | Continued From page 3<br><br>Fire Alarm System - Installation<br>A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity.<br>18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview, the facility failed to provide notification by audible and visible signals in accordance with NFPA 101, 2012 LSC Edition, Section 19.3.4.3.1, 9.6.3, 9.6.3.2, 9.6.3.6 and NFPA 72, 2010 LSC Edition, Section 18.5, 18.5.2.4, 24.4.2.20.9.<br><br>The deficient practice was evidenced by the following:<br><br>On 05/12/21 at approximately 10:05 AM, observation revealed the enclosed courtyard did not have any occupant notification devices, (horn/strobe tied into the fire alarm system).<br><br>The findings were verified by the Maintenance Director and Regional Plant Operations Director at the time of the observation's. | K 341 | 1. Enclosed courtyard had horn/strobe occupant notification system installed on May 27th 2021 and was tied into the facility fire alarm system<br>2. Maintenance supervisor and fire consultant inspected the exterior of the building on May 27th and saw no other areas that needed an occupant notification system.<br>3. Maintenance director or Fire consultant will round the building quarterly x4 to see if any other areas need a notification system.<br>4. Maintenance director will report his findings at the quarterly QA meeting. | |

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| K 341 | Continued From page 4<br><br>The Administrator was notified of the findings at the Life Safety Code exit conference at 02:45 PM, on 05/12/21. | K 341 | | |
| K 345 SS=E | NJAC 8:39-31.2(a)<br>Fire Alarm System - Testing and Maintenance<br>CFR(s): NFPA 101<br><br>Fire Alarm System - Testing and Maintenance<br>A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available.<br>9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, on 05/12/21 in the presence of the Maintenance Director and Regional Plant Operations Director, it was determined that the facility failed to inspect the fire alarm system semi-annually in accordance with NFPA 72.<br><br>This deficient practice was evidenced by the following:<br><br>A review of the facility's fire alarm inspection reports indicated that the semi-annual fire alarm system inspection was conducted on 09/01/20. The current date: 05/12/21 revealed that the system is overdue for inspection more than 2-months.<br><br>This fire alarm system uses sealed lead acid | K 345 | 1) Fire alarm was inspected on May 17,2021<br>2) All other fire inspections were done in a timely manner<br>3) Maintenance director will have a monthly checklist to review for all required inspections<br>4) Administrator or corporate Maintenance director will review quarterly x 4 to ensure the inspections are done in a timely manner and report its findings at the quarterly QA meeting. | 6/4/21 |

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| K 345 | Continued From page 5<br>batteries that are required to be visually and functionally tested semi-annually.<br><br>In an interview, at 1:40 PM, the Maintenance Director stated that some inspections were delayed due to manpower issues with their current vendor.<br><br>The Administrator was informed of the findings at the Life Safety Code exit conference at 2:45 PM,<br><br>NJAC 8:39-31.1(c), 31.2(e)<br>NFPA 70, 72 | K 345 | | |
| K 353 SS=D | Sprinkler System - Maintenance and Testing<br>CFR(s): NFPA 101<br><br>Sprinkler System - Maintenance and Testing<br>Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.<br>a) Date sprinkler system last checked<br>_____<br>b) Who provided system test<br>_____<br>c) Water system supply source<br>_____<br>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.<br>9.7.5, 9.7.7, 9.7.8, and NFPA 25<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview, the facility | K 353 | 1) | 6/25/21 |

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| K 353 | Continued From page 6<br>failed to maintain the sprinkler system, ensuring the ceiling level was smoke resisting in accordance with NFPA 101, 2012 Edition, Section 19.3.5.1, 4.6.12, 8.5.6, 8.5.6.2 and 9.7. NFPA 25, 2011 Edition, Section 5.1, 5.2.2.1. The deficient practice of failing to provide a complete smoke resisting ceiling at the level of the installed sprinklers would not ensure prompt and proper operation of the sprinklers. Based on observation and interview, the facility failed to maintain the sprinkler system, ensuring sprinklers free from loading (obstruction), sprinklers obstructed by devices and piping from detecting fire and proper distribution of water in accordance with NFPA 101, 2012 Edition, Section 19.3.5.1, 4.6.12, 9.7.5 and NFPA 25, 2011 Edition, Section 5.1, 5.2.1.1.2, 5.4.1.4 and NFPA 13, 2010 Edition, Section 7.1.4, 8.5.5.2.1, 8.5.6.1.<br><br>The deficient practice was evidenced by the following:<br><br>1. The surveyor observed on 05/12/21 at approximately 12:50 PM during the facility tour, revealed in the basement east housekeeping/ laundry Room area where the hot water tank is located that approximately two 2' x 4' ceiling tiles are missing from the ceiling tracks. A round ceiling vent was missing a 2' x 2' ceiling tile and a corner vent approximately 6" x 1' was missing a ceiling tile, The room had 2-sprinkler heads and was not properly fire stopped allowing hot gases and smoke pass the sprinklers into the space above.<br><br>2. The facility provided the fire sprinkler inspection report, dated 03/01/21 and under device deficiencies : (Inspection Results Summary Antifreeze System "failed") | K 353 | A) Tiles and ceiling vent were replaced on May 12th, 2021 in the basement east housekeeping laundry room to ensure complete smoke resistant ceiling.<br>B) Sprinkler heads were replaced. Plastic curtains were installed to the freezer doorway to help ensure no further ice buildup.<br><br>2)<br>A) All other areas in the building were inspected all other area was found to be smoke sealed<br>B) All other sprinkler heads were inspected and no other heads have any evidence of ice buildup.<br>3)<br>A) Maintenance director or designee will continue to monitor all areas of the building to ensure all areas are smoke sealed monthly x 3 months and quarterly x 4, thereafter.<br>B) Maintenance director or designee will inspect monthly x 3 months for any ice buildup and quarterly x4 thereafter.<br>4)<br>Corporate Maintenance director/ designee will round Quarterly x 4 to ensure that all areas are smoke sealed and that there is no ice buildup on sprinkler heads. Finding will be reported at quarterly QA committee. | |

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| K 353 | Continued From page 7<br><br>Description : Kitchen 2" line with 2" OSY,<br>Device : Antifreeze System<br>Date of Test: 03/01/21<br>Type: Visual Failure<br>Failure reason: Ice on piping in freezer also 2-heads inside need to be changed to dry type.<br><br>The findings were verified by the Maintenance Director and Regional Plant Operations Director at the times of the observation.<br><br>The Administrator was notified of the findings at the Life Safety Code exit conference.<br><br>NJAC 8:39-31.2(e)<br>NFPA 25 | K 353 | | |